Early and Periodic Screening Diagnosis and Treatment
TRACKING FORM
6 MONTHS

TO BE FILLED IN BY OFFICE STAFF:

Last Name	First Name	AHCCCS ID	D.O.B.	Age

Primary Care Provider	Date of Examination	Health Plan Name

Birth Wt.	Weight	Percentile	Height	Percentile	Head Circumference	Percentile

TO BE FILLED IN BY PROVIDER

HISTORY INITIAL/INTERVAL
Comments

T _____
P _____
R _____

NUTRITIONAL ASSESSMENT [ ] Breast Feeding [ ] Formula (type) _____
Supplements: [ ] Fluoride [ ] Vitamins [ ] Iron [ ] Solids

SENSORY ASSESSMENT Vision: Within normal limits? [ ] Yes [ ] No, Refer
Hearing/Speech: Within normal limits? [ ] Yes [ ] No, Refer

DEVELOPMENTAL ASSESSMENT Age appropriate? [ ] Yes [ ] No
Vocalizes single consonants, "dada", rolls over, no head lag when pulled to sit, sits with support, transfers small objects hand to hand. (If suspicious, do specific objective testing) Assessment Tool (name) _____

PHYSICAL EXAM

Are the following normal?

	Yes	No
Skin		
Head		
Eyes		
ENT		
Teeth		
Nodes		
Heart		
Lungs		
Abdomen		
Ext. Gen.		
Extremities		
Spine/Neuro		

LAB/SCREENING

Hgb. or Hct.		
	High	Low
Lead Screen: Verbal Risk		

COMMENTS, ASSESSMENT & PLAN

Follow-up needed? [ ] Yes [ ] No

IMMUNIZATION ASSESSMENT

Did this child receive all immunizations due today? [ ] Yes [ ] No
Is there a current immunization record in the medical chart? [ ] Yes [ ] No

ANTICIPATORY GUIDANCE

[ ] Injury prevention
[ ] Cup, finger foods
[ ] No bottle in bed
[ ] Pool & tub safety
[ ] Teething
[ ] Poisons - ipecac
[ ] Nutrition
[ ] Sleep positioning

REFERRALS

[ ] CRS
[ ] WIC
[ ] Specialty _____
[ ] Other

Next scheduled visit	Clinician Name	Clinician Signature

Was this claim coded as an EPSDT Visit (HCFA-1500)? [ ] Yes [ ] No